Health Information Management Compliance

A Model Program for Healthcare Organizations

2002 Edition

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AHIMA
AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION®

Contents

About the Author

Sue Prophet, RHIA, CCS, is the Director of Coding Policy and Compliance for the American Health Information Management Association (AHIMA). She earned a bachelor of science degree in medical record administration from Daemen College in Amherst, New York, and earned the credentials of registered health information administrator (RHIA) and certified coding specialist (CCS) through AHIMA. Prior to her current position, she held management positions in health information management and utilization review in an acute care facility.

Sue is responsible for AHIMA's initiatives related to coding policy and compliance. She participates in the development of the Official ICD-9-CM Guidelines for Coding and Reporting and the content of the American Hospital Association's *Coding Clinic for ICD-9-CM.* Sue represents AHIMA in meetings of the ICD-9-CM Coordination and Maintenance Committee and the American Medical Association's CPT Editorial Panel. She has participated in the development of the Office of Inspector General's (OIG) compliance program guidances, including the guidance documents for hospitals, home health agencies, third-party billing companies, the hospice and nursing home industries, and physician office practices. Sue has provided health information management consultative services to the OIG, Federal Bureau of Investigations, and Department of Justice on fraud and abuse and compliance issues. She has provided an educational program to OIG officials on health record documentation and coding practices. She has written numerous articles and provided a number of media interviews on fraud/abuse, compliance, and coding issues. Sue has also given a number of presentations on issues related to coding and compliance.

Introduction

The American Health Information Management Association (AHIMA) has developed this model HIM compliance program to assist healthcare organizations in formulating their own programs to ensure compliance with applicable reimbursement regulations and policies with respect to health information management (HIM). (See appendix D for AHIMA's official position statement on quality healthcare data and information.)

This model program is not intended to be implemented by healthcare organizations "as is." Rather, the elements contained in this model program are intended to provide guidance to healthcare organizations as they design, implement, and refine their own HIM compliance programs.

Every healthcare organization must design an HIM compliance program that meets its internal needs and addresses its specific risks. One size does not fit all. The actual content of the program depends on a number of characteristics unique to the organization, including culture, size, structure, setting type (clinic, acute care hospital, long-term care facility), and operational processes.

The Office of Inspector General within the Department of Health and Human Services (HHS) encourages the provider community to become involved in an extensive, good faith effort to work cooperatively on voluntary compliance to minimize errors and to prevent potential penalties for improper billings before they occur. As a result of this initiative, healthcare organizations have developed "corporate compliance programs." An HIM compliance program is the component of a corporate compliance program that delineates policies/procedures and other requirements focused on health information management. It must be developed in concert with the corporate compliance program because it must support the corporate program and have the commitment of the organization's top-level management. Because the compliance program encompasses health information management organizationwide, it is not confined to the boundaries of the HIM department.

A sincere effort by healthcare providers to comply with federal laws and regulations through an effective compliance program is a mitigating factor toward reducing a provider's liability. However, consideration of a reduction in penalties will occur only when the provider can demonstrate that an effective compliance program was in place

before a criminal or civil investigation began. A compliance program will be effective in preventing and detecting regulatory violations when it has been reasonably designed, implemented, and enforced to do so. Moreover, an effective HIM compliance program is essential to the success of a corporate compliance program because the cornerstone of health information management—documentation of the provision of healthcare services—is the cornerstone of fraud investigations and the evidence of compliance. (See appendix A for a description of HIM background and skills.)

HIM compliance program effectiveness is measured by the success of the outcome (that is, compliance), not by the impressiveness of the processes that have been created. Additionally, the size and scope of a compliance program are not necessarily indicators of its effectiveness. An important objective is to *keep it simple.* Most organizations already have many elements of a compliance program in place. Existing policies, procedures, and standards (policies and procedures pertaining to coding, documentation practices, and health record completion requirements) need to be brought under the umbrella of the compliance program.

Each organization has an affirmative duty to ensure the accuracy of the claims it submits for reimbursement. A sound compliance program requires that reasonable measures be instituted to detect errors and potential fraud in the claims preparation process. Thus, there must be evidence of compliance through detecting, correcting, and preventing coding and billing problems and documentation deficiencies. It is important to note that providers are not subject to criminal, civil, or administrative penalties for innocent errors or negligence. The civil False Claims Act covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim. The Civil Monetary Penalties Law has the same standard of proof. For criminal penalties, a criminal intent to defraud must be proved beyond a reasonable doubt. While not fraud, innocent billing errors are a significant drain on our health care reimbursement systems. Therefore, providers, Medicare contractors, government agencies, and consumers need to work cooperatively to reduce the overall error rate.

It is not enough to simply develop a compliance program. In addition to being effective, the program must have the full commitment of the organization's governing body, management, and employees. Adherence must be demonstrated at all levels of the organization. The Office of Inspector General (OIG) in the Department of Health and Human Services has indicated that it will consider a poor compliance program, or lack of adherence to the program, as being worse than having no program at all. Compliance controls need to be integrated into the very fabric of the healthcare organization's operations. A compliance program is never finished; rather, it is an ongoing, evolving process for continuous quality improvement.

Sample Audit Tools on Disk

The following sample audit tools are available on the enclosed computer disk, were created using Microsoft Word, and are compatible with Word 97–2000 and 6.0/95–RTF:

- Ambulatory coding review worksheet
- Coding audit review sheet
- Coding audit summary
- Coding compliance review: Inpatient summary
- Coding compliance review: Outpatient summary
- Coding DRG variation form
- Coding services review tool
- Coding validation worksheet
- Compliance audit
- Daily worksheet: Inpatient cases
- HHPPS coding audit tool (©2002 hiqmConsulting)
- Inpatient rebilling log
- Inpatient review: Variations by coder
- OBQM clinical record review: UTIs (©2002 hiqmConsulting)
- OBQM clinical record review: Wounds (©2002 hiqmConsulting)
- Outpatient rebilling log
- Prebill review form
- Rebilling log
- Rebilling summary coding change
- Rehabilitation functional independence measure (©2002 Patricia Trela and Anna Tran)
- Rehabilitation patient assessment instrument (©2002 Patricia Trela and Anna Tran)
- SNF PPS compliance audit: Medicare Part A
- Statistics for coding quality monitoring